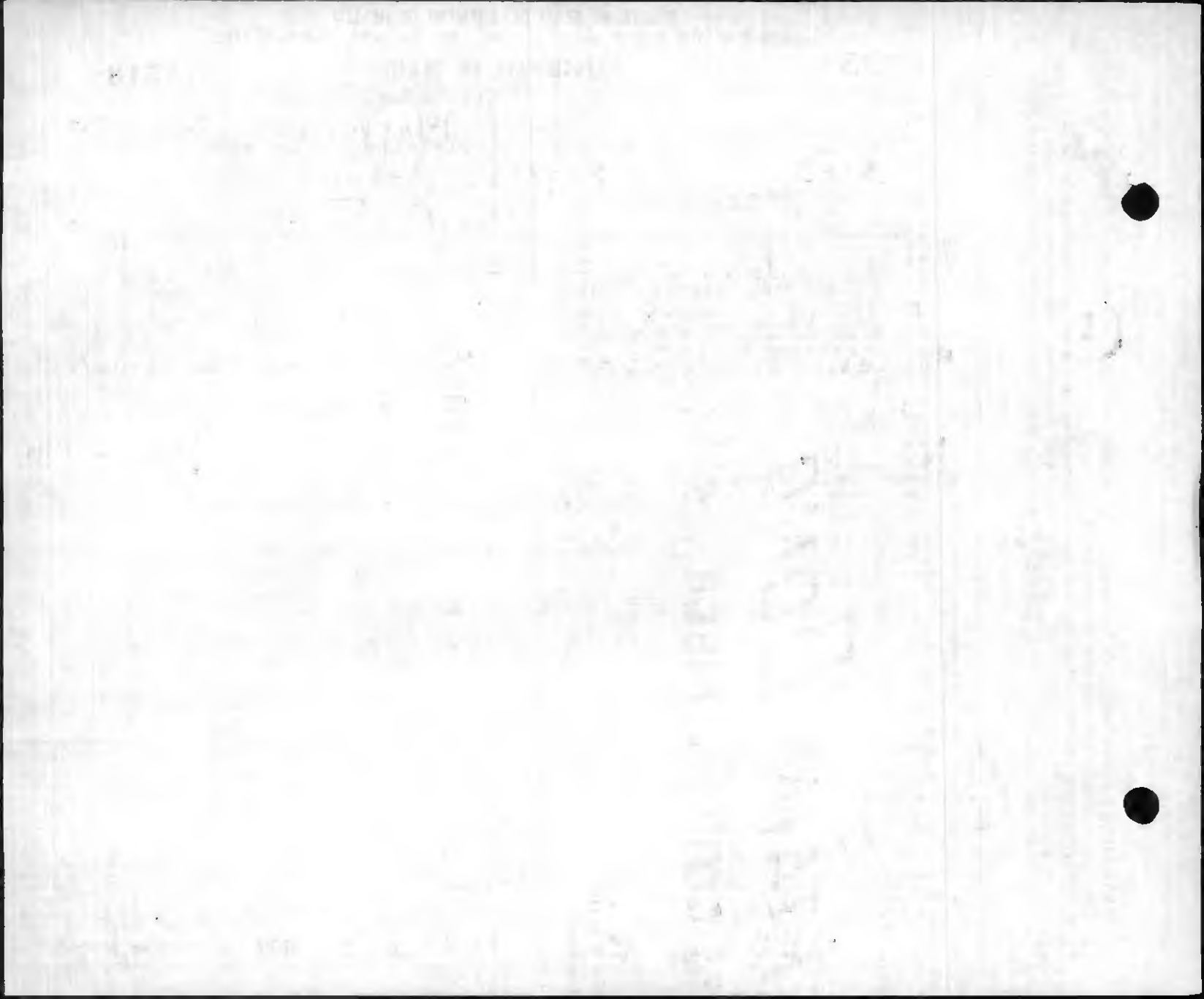


18518

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-14-64
30M REV. 1/68

18506										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18519																																																											
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
Maggie Deland Gray										Dec. Month 30 Day 1968										1 A. M.																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										7. UNOER 1 YEAR										8. UNOER 24 HRS.																													
Female										White										Oct. 7, 1869										99 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. COUNTY OF DEATH										Md.																																							
Maryland										USA																				Worcester																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Bishopville										RFD										Housewife										Own home																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																																							
Maryland										Worcester										Bishopville										YES										RFD																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																					
John Gray										Mellie Hunting																																																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																	
XX										XX										No										Mrs Campbell Bishopville, Md.																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Cerebral thrombosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
4339										DUE TO, OR AS A CONSEQUENCE OF																																																																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) arteriosclerosis																																																																					
										DUE TO, OR AS A CONSEQUENCE OF																																																																					
										(c)																																																																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										332X																																																																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from Mar. 18, 1966, to Dec. 30, 1968, that (I) (we) last saw the deceased alive on June 15, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										22c. DATE SIGNED																																																																					
Jack C. Lewis										Jan. 2, 69																																																																					
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
Jack C. Lewis, M. D.										Selbyville, Delaware																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
Burial										1/1/69										Zion Church Yards										Bishopville Worcester Md.																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
Peter Whaley										Selbyville, Del.										DATE JAN 6 1969										Charles Judge																																																	

Handwritten notes and a table. The table has several columns and rows of data, including numbers and text. The handwriting is cursive and somewhat faded.

Handwritten notes at the bottom of the page, including a date and some text. The handwriting is cursive and somewhat faded.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

18507

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18520

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY WOR	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin - RURAL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Office of Dr. Townsend		d. STREET ADDRESS Route 3 Box 52	
3. NAME OF DECEASED (Type or print) GARDNER Charles JARMON		4. DATE OF DEATH Dec 16 1968	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 12, 1918
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CHICKEN	
11. BIRTHPLACE (County & State, or foreign country) Berlin, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CARL JARMON		14. MOTHER'S MAIDEN NAME VERGIE BRIDGELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Dorothy E. JARMON, wife		Address SAME ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA prostate, wide metastasis 185X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 142 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 177X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN 16, 1968 to Dec 16, 1968 , that (I) (we) last saw the deceased alive on Oct 28, 1968 , and that death occurred at 10:24 A.M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED Dec 16, 68	
22c. PHYSICIAN'S NAME (Type) F J Townsend, Jr		22d. ADDRESS Ocean City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12-21-68	23c. NAME OF CEMETERY OR CREMATORY Evergreen	23d. LOCATION (City or Town) (County) (State) Berlin, Wor. Md.
24. FUNERAL DIRECTOR Loretta B. Jolley Jersey City, N.J.		25a. REC'D BY REGISTRAR DEC 24 1968	
25b. REGISTRAR'S SIGNATURE [Signature]			

03321

STATE OF MARYLAND

1932

03321 1-1-33

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18521

18508

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First Middle Last ROBERT EDWARD MERRITT			2a. DATE OF DEATH Month Day Year December 7, 1968		2b. HOUR 1:30 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH August 24, 1914		6. AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WORCESTER Md.		
10. CITY OR TOWN OF DEATH Girdletree	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bay Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waterman	12b. KIND OF BUSINESS OR INDUSTRY Seafood		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Worcester	13c. CITY OR TOWN Girdletree	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Bay Road	
14. FATHER'S NAME First Middle Last William Porter Merritt		15. MOTHER'S MAIDEN NAME First Middle Last Sarah -- Bowden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) yes WW 2		16b. SOCIAL SECURITY NO. 223-16-4060		17. INFORMANT Address Mrs Dixie B. Merritt, Girdletree, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4109					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours Many years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from <u>September, 1968</u> , to <u>Dec. 7, 1968</u> , that (2) (we) last saw the deceased alive on <u>Dec. 7, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lloyd O. Long, M.D.				22c. DATE SIGNED 12-9-68	
22d. PHYSICIAN'S NAME (Type) Lloyd O. Long, M.D.		22e. ADDRESS 104 N. Bay Street, Snow Hill, Md. 21863			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-9-1968	23c. NAME OF CEMETERY OR CREMATORIUM Springhill Cemetery	23d. LOCATION (City or Town) (County) (State) Girdletree - Wor. - Md.		
24. FUNERAL DIRECTOR Robert H. Watson		ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR DATE DEC 13 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

1923

RECORD OF THE

DEC 1 1923

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) Ernest Lloyd Parsons					2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Dec Day 7 Year 1968						
3. SEX M		4. RACE W		5. DATE OF BIRTH Dec. 7, 1901		6. AGE (In years last birthday) 67 YRS.		2c. DATE PRONOUNCED DEAD Month Dec Day 7 Year 1968			
7a. BIRTHPLACE (State or foreign country) Ocean City, Md. U.S.A.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Worcester Md.			
10. CITY OR TOWN OF DEATH Rural-Ocean City			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Md			13b. COUNTY Wor			13c. CITY OR TOWN Ocean City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Golf Course Rd.	
14. FATHER'S NAME First Ernest G. Parsons Middle G. Last Parsons					15. MOTHER'S MAIDEN NAME First Mary Hester Middle Davis Last Davis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 220-12-0819			17. INFORMANT Mrs. E. L. Parsons			ADDRESS Ocean City, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXSANGUINATION											
DUE TO, OR AS A CONSEQUENCE OF (b) Amputation, traumatic ARM AT Shoulder											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 9/20											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 150 P.M. Dec 7 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Power saw blade broke and struck him.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. R1 Ocean City		City or Town Wor		County Md State 21842			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE F. S. Townsend, Jr.			EXAMINER'S NAME (Type) F. S. Townsend, Jr.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED Dec 7, 68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/10/68		23c. NAME OF CEMETERY OR CREMATORY TAYLORVILLE			23d. LOCATION (City or Town) BERRY WOE, MD (County) (State)			
24. FUNERAL DIRECTOR Anna A. Burbridge Berlin			ADDRESS Md			25a. RECD BY REGISTRAR DEC 11 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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18510

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18523

1. DECEASED-NAME (Type or Print)			First ROY			Middle LEVERTON			Last PATRICK			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Dec. 20 1968				2b. HOUR 1:40 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 26, 1905		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD December 20 1968				2d. HOUR 2:00 PM	
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Worcester Md.					
10. CITY OR TOWN OF DEATH Snow Hill				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) on Penn-Cent R.R. 1 mile N. of Snow Hill Md								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Delmarva Elec. & Power Co. Employee				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland				13b. COUNTY Wicomico				13c. CITY OR TOWN Mardela Springs				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER R.F.D.			
14. FATHER'S NAME First Middle Last Edward Patrick						15. MOTHER'S MAIDEN NAME First Middle Last Elma Eaton											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes				16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 214-03-2988				17. INFORMANT ADDRESS Leroy Patrick, Harrington, Del., RFD #3									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock due to Crush Injury DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8109 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 800X																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) He was crushed between a truck & a railroad locomotive																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b. TIME OF INJURY 12:20 AM P.M. 1:40 PM 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Abdomen crushed between truck and locomotive					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) on rd track						21f. LOCATION Street or R.F.D. No. City or Town County State 1 mile N of Snow Hill, Md. Worc.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Robert C. La Mar</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 12-23-68					
EXAMINER'S NAME (Type) Robert C. La Mar, M.D. 104 Bay St Snow Hill, Maryland						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE Dec. 22, 1968						23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery					
23d. LOCATION (City or Town) (County) (State) Preston, Maryland						23e. REC'D BY REGISTRAR JAN 3 1969						23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
24. FUNERAL DIRECTOR Frampton Funeral Home, Federalsburg, Maryland																	

84761

STATE OF
NEW YORK

IN SENATE
January 10, 1917
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 10, 1916
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS
1917

THE LAND OFFICE OF THE STATE OF NEW YORK
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF
YOUR LETTER OF THE 27TH INSTANT, REQUESTING
A COPY OF THE REPORT OF THE COMMISSIONER OF THE
LAND OFFICE, IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE, MAY 10, 1916.
THE REPORT IS HEREBY FURNISHED TO YOU.
VERY RESPECTFULLY,
COMMISSIONER OF THE LAND OFFICE

84761 84761

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18511

18524

1. DECEASED-NAME (Type or print) <i>Beulah</i> First Middle Last			2a. DATE OF DEATH <i>Dec 7</i> Month Day Year <i>68</i> ?			2b. HOUR <i>?</i> M	
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>Mar. 26, 1883</i>		6. AGE (In years lost birthday) <i>85</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Worcester</i> Md.	
10. CITY OR TOWN OF DEATH <i>Pocomoke</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rural Pocomoke</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Teacher</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Worcester</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER <i>Route 2 Bx. 151</i>	
14. FATHER'S NAME First Middle Last <i>Francis Quinn</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Cassie Melvin</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Christine Quinn</i> Address <i>409 Edgewood Ave. N.Y.C.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>stroke</i> <i>4120</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardio-Vascular disease</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>443x Diabetes</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>N.E. Santorinus Sr.</i>				22c. DATE SIGNED <i>12/14/68</i>		22d. PHYSICIAN'S NAME (Type) <i>N.E.</i>	
22e. ADDRESS <i>Pocomoke City, Md.</i>				22f. ADDRESS <i>Pocomoke City, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-17-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hall's Hill Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Pocomoke Wor. Md.</i>	
24. FUNERAL DIRECTOR <i>Samuel...</i>		25a. REC'D BY REGISTRAR <i>DEC 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

